MOTUS HEALTH
Designed for More

Account Number: _____

# INITIAL APPLICATION FOR CARE

## PATIENT DEMOGRAPHICS

Name: _____ Birth Date: ____/____/____ Sex: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Phone#: _____ Social Security#: _____

Will you be using insurance? ☐ Yes ☐ No Ins. Co. Name: _____ Policy Number: _____

Group Number: _____ Ins. Co. Phone Number on Card: _____

Is today's visit the result of an accident? ☐ Yes ☐ No **If yes,** please provide claim number: _____

Emergency Contact Name/ Number: _____ /_____ Relationship: _____

Primary Care Physician: _____ Office Name: _____

Specialist Physician: _____ Office Name: _____

How did you hear about our office? _____

## HEALTH CONCERNS

Primary Concern: _____ Secondary Concern: _____

_____ _____

_____ _____

On a scale of **0** to **10** with **ZERO** being none at all and **TEN** being the worst possible, please rate your above concerns by ***checking the box:***

**Primary** concern is: 0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

**Second** concern is: 0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

When did the problem(s) begin? ____/____/____

How did it happen? _____

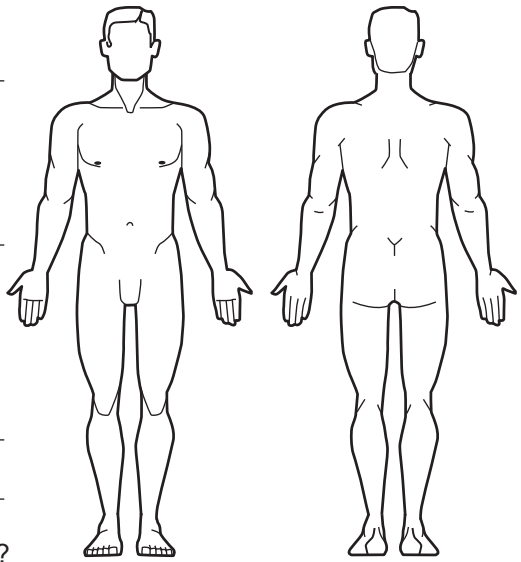
When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late night

How long does it last? ☐ Constant ☐ Off and on during the day

What does it feel like? _____

**ON THE DIAGRAM please mark your symptoms using the following letters:**

**R = R**adiating **B = B**urning **D = D**ull **A = A**ching **N = N**umbness
**S = S**harp/**S**tabbing **T = T**ingling



What relieves your symptoms? _____

What makes your symptoms worse? _____

Any other facts about this current issue that you feel the doctor should know about?

_____

_____

## PREVIOUS HISTORY

Have you experienced these same issues in the past? ☐Yes ☐No **If yes,** how long have you been dealing with them?_____

Have you tried other treatments in the past? ☐ Yes ☐ No **If yes,** please list all previous doctors you have seen: _____

**As well as** any and all products, procedures, medications, or supplements you have tried prior to now for this condition: _____

What were the results of your prior treatments? _____

## QUALITY OF LIFE QUESTIONNAIRE

How has your health condition(s) affected your job? Your finances? Your relationships? Your family? Your hobbies or other activities? Please give examples:

What has that ended up costing you? (Time, Money, Freedom, Sleep, Promotions, Happiness, etc.) Please give examples:

What are you most concerned about regarding your condition?

Where do you see yourself in the next 1-3 years if this problem is not taken care of? Please be specific:

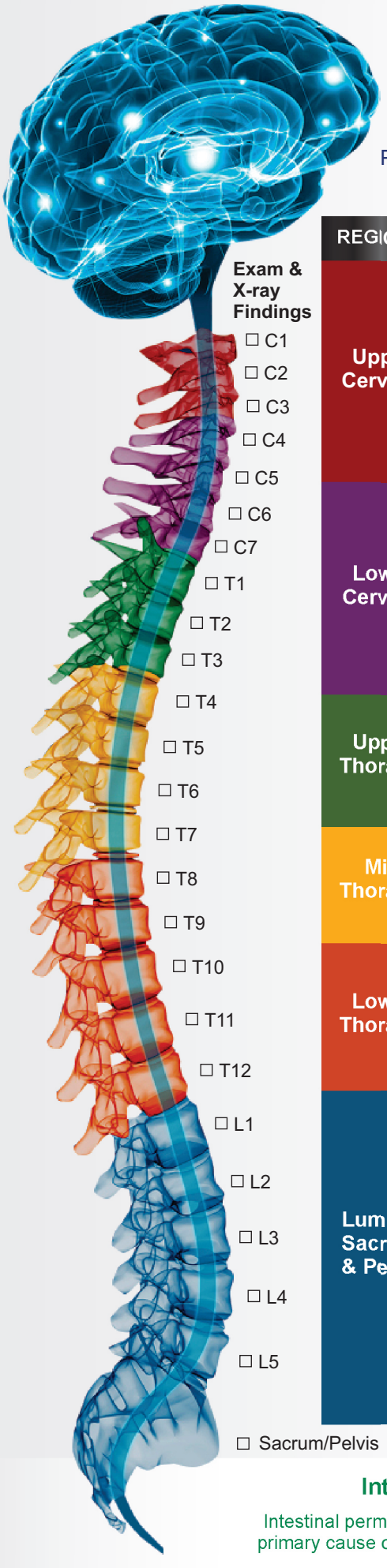
What would instantly be different or better about your life if we could take this problem away immediately?

What do you desire most to get from working with us?

# Review of Systems

The nervous system controls and coordinates all organs and structures of the human body.

Please answer the following symptom checklist as thoroughly as possible by marking if you have **ever had** or **currently have** any of the following.




| REGIONS | FUNCTIONS | SYMPTOMS | |
|---|---|---|---|
| | | ☐ PAST ☐ PRESENT | ☐ PAST ☐ PRESENT |
| **Upper Cervical** | • Autonomic Nervous System<br>• ENT System<br>• Vision, Balance & Coordination<br>• Speech<br>• Immune System | ☐☐ Colic & Excessive Crying<br>☐☐ Ear & Sinus Infections<br>☐☐ Allergies & Congestion<br>☐☐ Immune Deficiency<br>☐☐ Headaches & Migraines<br>☐☐ Vertigo & Dizziness<br>☐☐ Sore Throat & Strep | ☐☐ Epilepsy & Seizures<br>☐☐ Sensory & Spectrum<br>☐☐ ADD / ADHD<br>☐☐ Focus & Memory Issues<br>☐☐ Anxiety & Stress<br>☐☐ Balance & Coordination<br>☐☐ Speech Issues |
| **Lower Cervical** | • Digestive System<br>• Nerve Supply to Shoulders, Arms & Hands<br>• Sympathetic Nucleus<br>• Metabolism | ☐☐ Swollen Tonsils & Adenoids<br>☐☐ Vision & Hearing Issues<br>☐☐ Low Energy & Fatigue<br>☐☐ Difficulty Sleeping<br>☐☐ Pain, Numbness & Tingling in Arms to Hands<br>☐☐ Poor Circulation/cold Hands | ☐☐ TMJ / Jaw Pain<br>☐☐ Neck and shoulder pain<br>☐☐ Nausea/vomiting<br>☐☐ Depression<br>☐☐ High Blood Pressure<br>☐☐ Poor Metabolism & Weight Control |
| **Upper Thoracic** | • Upper G.I.<br>• Respiratory System<br>• Cardiac Function<br>• Upper Back Pain | ☐☐ Reflux / GERD<br>☐☐ Chronic Colds & Cough<br>☐☐ Asthma<br>☐☐ Mid Back Pain | ☐☐ Bronchitis & Pneumonia<br>☐☐ Heart Conditions<br>☐☐ Irregular Heart Beat<br>☐☐ Low Blood Pressure |
| **Mid Thoracic** | • Major Digestive Center<br>• Detox & Immunity | ☐☐ Gallbladder Pain / Issues<br>☐☐ Jaundice<br>☐☐ Fever | ☐☐ Indigestion & Heartburn<br>☐☐ Stomach Pains & Ulcers<br>☐☐ Blood Sugar Problems |
| **Lower Thoracic** | • Stress Response<br>• Filtration & Elimination<br>• Gut & Digestion<br>• Hormonal Control | ☐☐ Behavior Issues<br>☐☐ Hyperactivity<br>☐☐ Fatigue<br>☐☐ Chronic Pain<br>☐☐ Inflammation | ☐☐ Psoriasis and Eczema<br>☐☐ Skin Conditions / Rash<br>☐☐ Kidney Problems<br>☐☐ Gas Pain & Bloating<br>☐☐ Chronic Stress |
| **Lumbar, Sacrum & Pelvis** | • Lower G.I. (Absorption & Motility)<br>• Gut-Immune System<br>• Major Hormonal Control | ☐☐ Constipation<br>☐☐ Chrohn's, Colitis & IBS<br>☐☐ Mucus or Blood in Stool<br>☐☐ Diarrhea<br>☐☐ Bed-wetting<br>☐☐ Bladder & Urination Issues<br>☐☐ Menstrual issues<br>☐☐ Erectile Dysfunction<br>☐☐ Cysts & Endometriosis<br>☐☐ Infertility / Impotency<br>☐☐ Hemorrhoids<br>☐☐ Hip/ Knee Pain | ☐☐ Sciatica & Radiating Pain<br>☐☐ Lumbopelvic / SI Joint Pain<br>☐☐ Hamstring Tightness<br>☐☐ Disc Degeneration<br>☐☐ Leg Weakness & Cramps<br>☐☐ Poor Circulation & Cold Feet<br>☐☐ Pain, Numbness, and Tingling in Legs and Feet<br>☐☐ Weak Ankles & Arches<br>☐☐ Lower Back Pain<br>☐☐ Food Sensitivities |

**Intestinal Permeability/Leaky Gut Index Score_____**

Intestinal permeability (aka leaky gut) is seldom tested for in general medical practice, but it is the primary cause of many chronic health issues we face today. All green shaded items throughout this form are used in the calculation of this score.

## ACTIVITIES OF DAILY LIVING LIMITATIONS

Please identify how your current condition is affecting your ability to carry out activities of your daily life:

| ACTIVITY | EFFECT | | | |
|---|---|---|---|---|
| Carry/Lift Groceries | ☐ No Effect | ☐ **Slightly** Limited | ☐ **Very** Limited | ☐ Unable to Perform |
| Sit to Stand | ☐ No Effect | ☐ **Slightly** Limited | ☐ **Very** Limited | ☐ Unable to Perform |
| Climb Stairs | ☐ No Effect | ☐ **Slightly** Limited | ☐ **Very** Limited | ☐ Unable to Perform |
| Pet Care | ☐ No Effect | ☐ **Slightly** Limited | ☐ **Very** Limited | ☐ Unable to Perform |
| Extended Computer Use | ☐ No Effect | ☐ **Slightly** Limited | ☐ **Very** Limited | ☐ Unable to Perform |
| Tend to Children | ☐ No Effect | ☐ **Slightly** Limited | ☐ **Very** Limited | ☐ Unable to Perform |
| Read/Concentrate | ☐ No Effect | ☐ **Slightly** Limited | ☐ **Very** Limited | ☐ Unable to Perform |
| Getting Dressed | ☐ No Effect | ☐ **Slightly** Limited | ☐ **Very** Limited | ☐ Unable to Perform |
| Shaving | ☐ No Effect | ☐ **Slightly** Limited | ☐ **Very** Limited | ☐ Unable to Perform |
| Washing/ Bathing | ☐ No Effect | ☐ **Slightly** Limited | ☐ **Very** Limited | ☐ Unable to Perform |
| Sexual Activities | ☐ No Effect | ☐ **Slightly** Limited | ☐ **Very** Limited | ☐ Unable to Perform |
| Sleeping | ☐ No Effect | ☐ **Slightly** Limited | ☐ **Very** Limited | ☐ Unable to Perform |
| Sitting | ☐ No Effect | ☐ **Slightly** Limited | ☐ **Very** Limited | ☐ Unable to Perform |
| Standing | ☐ No Effect | ☐ **Slightly** Limited | ☐ **Very** Limited | ☐ Unable to Perform |
| Yard Work | ☐ No Effect | ☐ **Slightly** Limited | ☐ **Very** Limited | ☐ Unable to Perform |
| Walking | ☐ No Effect | ☐ **Slightly** Limited | ☐ **Very** Limited | ☐ Unable to Perform |
| Driving | ☐ No Effect | ☐ **Slightly** Limited | ☐ **Very** Limited | ☐ Unable to Perform |
| Sweeping/Vacuuming | ☐ No Effect | ☐ **Slightly** Limited | ☐ **Very** Limited | ☐ Unable to Perform |
| Washing Dishes | ☐ No Effect | ☐ **Slightly** Limited | ☐ **Very** Limited | ☐ Unable to Perform |
| Taking out Garbage | ☐ No Effect | ☐ **Slightly** Limited | ☐ **Very** Limited | ☐ Unable to Perform |
| Doing Laundry | ☐ No Effect | ☐ **Slightly** Limited | ☐ **Very** Limited | ☐ Unable to Perform |
| Other_____ | ☐ No Effect | ☐ **Slightly** Limited | ☐ **Very** Limited | ☐ Unable to Perform |
| Other_____ | ☐ No Effect | ☐ **Slightly** Limited | ☐ **Very** Limited | ☐ Unable to Perform |
| Other_____ | ☐ No Effect | ☐ **Slightly** Limited | ☐ **Very** Limited | ☐ Unable to Perform |

**Comments on any of the above tasks:** _____

_____

## SOCIAL HISTORY

**Exercise frequency** *Type?* _____

☐ Daily ☐ 3-4xs/wk ☐ 1-2xs/wk ☐ Rarely ☐ Never

**Caffeine Usage** _____

☐ Daily ☐ Weekly ☐ Occasional ☐ Never

**Alcohol Usage** _____

☐ Daily ☐ Weekly ☐ Occasional ☐ Never

**Tobacco Usage** *Type and amount?* _____

☐ Daily ☐ Occasional ☐ Former ☐ Never

**Recreational Drug Usage** _____

☐ Daily ☐ Occasional ☐ Former ☐ Never

**NSAID Usage (Tylenol, Aspirin, Ibuprofen, etc.)** _____

☐ Daily ☐ Weekly ☐ Occasional ☐ Never

**Antibiotic Usage** _____

☐ twice or more per year ☐ 1x/year ☐ 1-2 times ever ☐ Never

**What is your occupation?** _____

**Retired?** ☐ Yes ☐ No _____

## PREVIOUS MEDICAL HISTORY

Please mark if you have **EVER HAD** any of the following conditions. Use the comments section to provide details:

**Illnesses and Injuries**

| | | |
|---|---|---|
| ☐ Cancer | ☐ Arthritis/Joint Pain | ☐ Aneurysm |
| ☐ Tumors | ☐ Osteoporosis | ☐ CVA/TIA (stroke) |
| ☐ Seizures | ☐ Broken bones | ☐ Heart Attack |
| ☐ Diabetes | ☐ Dislocations | ☐ Blood Clots |
| ☐ Autoimmunity | ☐ Car Accident | ☐ Heart Disease |
| ☐ Fibromyalgia | ☐ Concussions | ☐ Other_____ |

**Hospitalizations and Surgeries**

| Procedure | Date Performed |
|---|---|
| ☐ Orthopedic | ____/____/_____ |
| ☐ Spinal | ____/____/_____ |
| ☐ Cancer | ____/____/_____ |
| ☐ Other_____ | ____/____/_____ |
| ☐ Other_____ | ____/____/_____ |

**Comments:** _____

_____

_____

## FAMILY HISTORY

Has anyone in your immediate family (Parents, Grandparents, Siblings, or Children) suffered from any of the following?

☐ Heart Disease ☐ Hypertension ☐ Stroke ☐ Aneurysm ☐ Cancer ☐ Diabetes ☐ Other

☐ Unknown or Unremarkable (No history of disease or illness)

If yes, please explain: _____

_____

_____

## CURRENT MEDICATIONS/SUPPLEMENTS

Please list all medications, drugs, and supplements you currently take, the dosage, and the reason you take them:

☐ Separate List Attached

| Medication/Product | Dosage | Reason You Take Them | Date Started |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## ALLERGIES

Do you have any allergies to medications, supplements, foods, or other? ☐ **No known allergies** ☐ **Yes**

**If Yes,** please provide details on what the allergy is to, symptoms you experienced, what you currently do for treatment, and if it is well controlled or not. _____

_____

_____

*I have answered the above questions on this form to the best of my ability, and certify them to be true and accurate to the best of my knowledge. I hereby authorize payment to be made directly to Motus Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability, and that I will remain financially responsible to Motus Chiropractic for any and all services I receive at this office.*

_____ _____/_____/_____

**Patient or Authorized Person's Signature** **Date Completed**

_____ _____/_____/_____

**Doctor's Signature** **Date Completed**